ANALYTICAL AND BIBLIOGRAPHICAL NOTICES.

ART. XXI.—*Guy's Hospital Reports.* Edited by C. HILTON FAGGE, M. D., and ARTHUR E. DURHAM. Third Series, Vol. XV. 8vo. pp. xvii., 652. London: John Churchill and Sons, 1870.

THE present volume of these Reports will, it is believed, fully sustain the reputation possessed by this most excellent series. Many of the papers are illustrated by plates (two of them coloured) and by wood-cuts, there being twelve of the former and eleven of the latter. In accordance with our usual custom we present to our readers brief analytical and critical notices of all the contributions to this volume, and have grouped together first, those which relate to the various branches of practical medicine, and, secondly, those which refer to surgery.

Art. I. *Select Clinical Cases, including cases of Labio-Glosso-Laryngeal Paralysis; Exophthalmic Goitre; Arterial Pyœmia; General Chronic Arteritis; Saturnine Gout,* by SAMUEL WILKS, M. D.—*Labio-glosso-laryngeal paralysis* affects, as the name implies, the lips, mouth, tongue and larynx, and, therefore, as might be supposed, the functions of eating, swallowing and talking are much interfered with. The nerves known as the seventh, eighth and ninth are in part paralyzed. The following are said to be some of the phenomena presented by this affection: loss of expression, from partial paralysis of the facial nerves; loss of the power of utterance, from paralysis of the muscles not only of the face and tongue, but also of the larynx; difficulty of eating, from the fact that the food collects between the cheeks and gums; inability to swallow, or to retain the saliva; and absence of sensibility of both the velum and larynx. None of the muscles concerned in respiration are paralyzed.

Dr. Wilks, in explanation of this peculiar paralysis, says that "it has long been considered that there is a region in the medulla which may be called the respiratory tract, a region to which branches of all the nerves engaged in the respiratory process may owe their origin; in like manner it would appear that as a large number of parts are engaged in the act of talking, so the nerves supplying them must be stimulated from a common centre, and thus the explanation how so complex a function should suddenly cease from lesion of one small spot." Some observations of Mr. Lockhart Clarke go far towards proving that the above hypothesis is correct; for he has demonstrated that there is a close anatomical connection between the nuclei of the hypoglossal, vagus, spinal accessory, facial and trigeminal nerves, and it is well known that these nerves send branches to all the parts used in speaking. Five cases of this form of paralysis are reported. It sometimes accompanies hemiplegia, and, occasionally, progressive locomotor ataxia.

Three cases of exophthalmic goitre are next reported; one is of unusual interest from the fact that there was a post-mortem examination. In discussing the nature of this disease Dr. Wilks maintains that it is not likely to be due either to paralysis, or to excessive stimulation of the sympathetic, for in one case the heart's action would be diminished, and in the other the calibre of the vessels of the head and neck would be diminished. In the fatal case the cervical sympathetic and the ganglia were carefully examined. To the naked eye the only change to be discovered was an excessive development of fibrous tissue, and nothing further seems to have been detected by Dr. Moxon, who made a microscopical examination, for he tells us that "the microscopic character of the ganglia, like the macroscopic, only gave us, as signs of disease, an apparent excess of fibrous tissues in the structure of the ganglionic tissue, with an apparent enlargement of the capillary vessels. On the other hand, against this we find the natural minute elements of the ganglion to have a healthy appearance."

A plate representing the appearance of this patient accompanies this paper.

Arterial pyæmia, Dr. Wilks regards as a frequent accompaniment of chronic disease of the heart; the symptoms are, however, either entirely overshadowed by the more severe ones attendant on valvular disorder, or, if observed, thought to be dependent upon rheumatism. It may exist in cases in which there is no history of a primary heart affection, or it and endocarditis may be set up at the same time and by the same influences. It should be suspected wherever there are obscure febrile conditions, especially when these are accompanied by rigors and by a gradual increase in size of the liver and spleen.

Dr. Wilks, while fully acknowledging that valvular vegetations are the most frequent causes of obstruction of the arteries, says that there are many cases in which Rokitansky's view that the fibrin is directly deposited from the blood must be accepted, and others in which we can only suppose that the deposit in the vessels and that upon the valve must have taken place at the same time. These latter present many of the symptoms of venous pyæmia, the only difference being that the source of infection is in the interior of the body.

A case of general *chronic arteritis* is also reported. In this case some of the principal arteries in the body were so thickened and obstructed that their pulsations could only be felt with the greatest difficulty. The symptoms most complained of during life were severe pains in the limbs; these were sometimes so severe as to extort cries from the patient, and were only relieved by the subcutaneous injection of morphia. Other symptoms were excessive feebleness and great frequency of the pulse, great emaciation, feelings of numbness in the legs, tumultuous action of the heart, and slight albuminuria.

The association of *gout with plumbism* is so frequent that Dr. Wilks is inclined to think that either individuals with a gouty diathesis are more susceptible to the action of lead, or, that on the other hand, the action of lead may set up those mal-assimilations which result in the production of an excess of uric acid. Certain it is that we see in cases of what he designates as saturnine gout the same pathological changes in various tissues of the body as occur in pure gout, for instance—the degeneration of the bloodvessels and the granular contraction of the kidneys. The direct effects of lead upon the system are moreover not the same as those seen in cases where gout has supervened.

Art. VII. *On the Processes for Detecting Blood in Medico-Legal Cases*, by ALFRED S. TAYLOR, M. D., F. R. S.—In an article in the 13th volume of these Reports, which was noticed in the October number of this Journal for 1868, Dr. Taylor describes Van Deen's process for the detection of blood in medico-legal cases, by the employment of the peroxide of hydrogen and the freshly precipitated resin of guaiac. In the experiments there detailed the watery solution of the peroxide of hydrogen was used, but Dr. Taylor has since found so much difficulty in obtaining pure aqueous solutions of uniform strength and of good keeping qualities, from the constant presence of either sulphuric or hydrochloric acid, both of which affect the precipitated resin of guaiac, that he has lately used the ethereal solution sold under the name of ozonic ether.

To this paper is added an article "On the Detection of Blood by Means of the Spectrum-Microscope. By H. C. SORBY, F. R. S., &c. &c."

Art. VIII. *On "Tetany," or Remittent Tetanus*, by W. MOXON, M. D.—In the case reported by Dr. Moxon, a boy of 3 years of age, feeble and rickety, was the subject of peculiar seizures, which seem to have come on with difficulty of breathing, the breath being, to use the mother's words, "heavy, hard and short, as if he had inflammation on the chest." A little later the backs of the hands were observed to be swollen, and the hands and feet to be cramped; the thumbs being turned in across the palms and the forearms strongly pronated. The feet were generally similarly affected, the great toes flexed and adducted, and the other toes flexed and gathered towards them.

Dr. Moxon says this affection is undescribed in any of the works of the systematic writers on diseases of children. This is an error. A very good account of it is given by Messrs. Rilliet and Barthez, under the title "Contracture (Convulsion externe tonique)."

Art. X. *Remarks on Certain Cutaneous Affections; with Cases. Scleriasis; Ichthyosis; Pemphigus; Rhinoderma; Lichen Planus; Molluscum Contagiosum; Tinea Favus*, by C. Hilton Fagge, M. D.—It will be remembered that Dr. Fagge contributed to the 13th volume of *Guy's Hospital Reports* a paper on "Keloid, Scleriasis, Morphœa and some Allied Affections," which was noticed in the number of this Journal for October, 1868. It was there shown that the disease generally known as the Keloid of Addison is intimately allied to a complaint presenting some different characters, and first described by Thirial under the name of Sclérème des adultes, and more recently called Scleroma, Scleriasis or Sclerodermia. The keloid of Addison, Dr. Fagge looks upon as a chronic form of the disease, of which scleriasis is the acute. But since the duration of even the more transitory variety is very much longer than that of any disease ordinarily termed acute, he proposes to designate the two forms respectively as diffuse and circumscribed.

Dr. Fagge also reports a case of "*Diffuse Primary Carcinoma of the Skin*," which presents, he thinks, a striking resemblance to a case reported by Dr. V. Rasmussen, in the *Edinburgh Medical Journal*, for September and October, 1867, and regarded by him as a case of scleriasis.

Several cases of *ichthyosis* are reported, and some new facts in regard to this curious disease are to be found in this communication. Dr. Fagge dissents from Dr. Wilson's opinion that the form of ichthyosis which the latter calls xeroderma saurioides consists merely in "an altered state of the sebiparous function, and an accumulation of the sebaceous substance on the skin in the form of dark gray or greenish scales or spines," as he believes that in any disease to which the name of ichthyosis would be given at the present day, an alteration and hypertrophy of the papillæ of the corium and their epithelium will be found. A wood-cut is introduced to show the superposition of the epidermic scales, one above the other. Another wood-cut shows several hairs, with tufted extremities, lying side by side, but having their roots at different levels, all entangled in the epidermic scales. This arrangement Dr. Fagge regards as almost demonstrative proof that ichthyosis does not consist in an increased production of the epidermis, but rather in an abnormal adhesiveness of the epidermic scales, which enables them to resist the influences which ordinarily remove the superficial layers of the cuticle, and to remain heaped the one over the other, for it can hardly be doubted that all these hairs, embalmed as it were in a single ichthyotic scale, have been formed within the same follicle, and have been successively shed from it. From the cases reported, we learn that this cutaneous disease is often complicated with other eruptions, such as eczema, impetigo, and pemphigus, and that the subjects of it are occasionally stunted and deformed, from which Dr. Fagge argues its constitutional nature.

Several cases are referred to to show that Devergie's statement that "wherever a bleb appears without external cause the patient has pemphigus" is one that cannot be accepted without limitation. In one of the cases bullæ appeared on the skin of a woman exhausted by nursing, while their frequent appearance after injuries of nerve trunks, in urticaria, erythema nodosum, eczema, scabies, and in the anæsthetic form of elephantiasis Græcorum, is of course adverted to. A very interesting history of a case of pemphigus serpiginosus is included in the paper.

Under the name of *Rhinoderma* Dr. Fagge describes a disease, called by Devergie pityriasis pilaris, in which the skin is rendered rough like a rasp by the presence of horny accumulations in the mouths of the hair follicles.

The name of *Lichen planus* was given by Mr. Erasmus Wilson to an eruption of broad, flat papules of a crimson red colour, and having a smooth, shining, "glazed," or "burnished" surface. The papules are very little raised above the level of the skin, and are at first distinct, but after a time, as they increase in number, cohere together. Dr. Fagge has found the disease to be attended with a good deal of irritation of the skin, although the contrary is asserted to be the case by Mr. Wilson. Five cases are reported.

Molluscum contagiosum is referred to, partly for the purpose of introducing a plate taken from a drawing by Mr. Davies-Colley, of sections of a tumour removed from a child afflicted with this disease, and partly to record the fact that all Dr. Fagge's attempts to propagate this disease by inoculation had failed. In view, however, of the frequency with which this disease is found in different members of the same family, Dr. Fagge does not regard the failure of his experiments as proof that the disease is not contagious.

Tinea Favus forms the concluding subject of this paper. In all the cases, of which notes are given, epilation was practised, and with favourable results. A plate is appended to show that frequently in this disease a number of tubes may be contained within the hairs themselves, and it is to their presence that Dr. Fagge attributes the persistence and reappearance of the disease after all the crusts have been removed from the head by parasiticide lotions.

Art. XI. *Thermometric Observations in Clinical Medicine*, by J. F. GOODHART, House Physician.—This, although a very valuable paper, and one which shows much care in its preparation, does not admit of sufficient condensation to bring it within our limits. We can, therefore, only commend it to such of our readers as may be interested in the use of the thermometer in the study of disease. The diseases in which observations were made, are scarlatina, typhoid and typhus fevers, diphtheria, measles, febricula, syphilis, ague, relapsing fever, erythema nodosum, acute rheumatism, tubercular meningitis, tuberculosis, pleurisy, acute Bright's disease, and leucocythæmia. The action of medicine in causing a reduction of temperature is also recorded. From the observations which he has made, Dr. Goodhart is inclined to think that the rise in temperature in the early stage of typhoid fever is not a progressive one, as has been maintained by some German observers ; on the contrary, he believes that the thermometer will often fail to distinguish this from simple continued fever. A temperature of 107° Fahr. occurring in any other diseases than relapsing or intermittent fever he regards as invariably indicative of a fatal result.

In regard to the influence of the act of dying on the temperature, Mr. Goodhart says :—

1st. "That except in isolated instances, and these cases of long-standing disease with emaciation, the temperature is not materially lowered at the time of death.

2d. "That while a rapid rise of temperature is often observed, it occurs not in such cases as those of death from hemorrhage, accidents, collapse, etc., but rather in patients who are already so seriously ill that a difficulty with regard to them could scarcely arise."

Art. XII. *Cases Illustrating the Influence of Opium and some of its Constituent Principles in Controlling the Elimination of Sugar in Diabetes*, by F. W. PAVY, M.D., F. R. S.—Further experience has confirmed the favourable opinion formed by Dr. Pavy in regard to the power which opium and some of its preparations possess in controlling the elimination of sugar in diabetes. This paper contains the report of eleven cases so treated, and in all great improvement was effected. In some cases cure is even said to have taken place, but the latter is a statement which is contradicted by the fact that among the patients whose histories are detailed is that of the woman whose case was reported in vol. ii. of the *Clinical Society's Proceedings*, and noticed in the last number of this Journal, and who, notwithstanding that a complete recovery was supposed to have taken place, returned to the hospital with a recurrence of the diabetic condition of the urine. Of the preparations of opium, codeia and morphia appear to be most efficient and to give rise to the fewest unpleasant symptoms. On the other hand, narceia and narcotina appear to be inert, as far as concerns the possession of any power to restrain the excretion of sugar. Codeia has the great advantage over opium and morphia that it does not exert the same narcotic and constipating effects or diminish the appetite to the same extent. In one case, the case above alluded to as having been already noticed in this Journal, codeia sufficed to cause a disappearance of the sugar from the urine without a restriction of the diet. The dose of codeia is at first half a grain three times daily, and afterwards gradually increased. In some of Dr.

Pavy's cases the dose was increased gradually until ten grains three times a day were administered.

Art. XIV. *On the Necessity for a Clinical Nomenclature of Disease*, by W. Moxon, M.D.—This paper consists principally of a full criticism of the nomenclature of disease recently adopted by the Royal College of Physicians. As the latter has already been noticed in this Journal, it is not necessary to allude further to Dr. Moxon's remarks than to say that he thinks we ought "to have the names of diseases made to refer primarily and chiefly to their clinical nature; and secondly, to have an arrangement introduced such that the nature of a disease may be accurately defined apart from its anatomical results; and thirdly and chiefly, that the nomenclature shall correspond to the actual clinical grouping of the symptoms of disease, rather than to the anatomical or physiological divisions of the body and its functions."

Art. XV. *Cases of Successful Version after Failure of the Forceps*, by J. Braxton Hicks, M.D., F. R. S.—Five cases are reported by Dr. Hicks, in which, after the failure of the forceps, delivery was accomplished by turning. In another case, version was performed with complete success in the second labour, although in the first it had been thought necessary to have recourse to craniotomy. Dr. Hicks admits that it is quite possible that in most of these cases the use of an instrument of greater compressing power than is generally used in England might have rendered version unnecessary, but thinks that much more damage would be inflicted upon the tissues both of the mother and child; he never having seen a case in which there was any evidence of injury to the mother by traction after turning. The use of chloroform has, moreover, removed the greatest objection to turning—the pressure to which the funis may be subjected during delivery, as a thorough condition of relaxation of the uterus may be maintained during the operation.

Art. XVI. *Clinical Notes*, by S. O. Habershon, M.D.—Inflammation of the diaphragmatic pleura presents symptoms which differ very considerably from those usually seen in pleurisy. The pain is agonizing, and the patient dreads the necessary movement of inspiration. His expression is one of extreme suffering and distress, his countenance becomes lurid, and apnœa is threatened because he dare not breathe. If the right side be the one affected, the symptoms are often mistaken for those of disease of the liver; if the left side, they frequently give rise to the suspicion that the spleen, stomach, or heart is diseased. The circumstance that where the diaphragmatic surface is exclusively inflamed, no friction sound is heard, and the other physical signs are wanting, of course increases the difficulty of diagnosis very materially. The following are mentioned as some of the most frequent of the peculiarities presented by diaphragmatic pleurisy: The suddenness of the pain and its great intensity; the severity of the dyspnœa; the comparative absence of the physical signs, as well as of febrile excitement; the presence of pain in the shoulder; irritability of the stomach if the left, and jaundice if the right side be affected. Resolution of the inflammation is the most frequent termination of the disease, but in some cases effusion, and in others consolidation of the lung results. The pain in the right shoulder and the irritability of the stomach are explained by the nervous connections between those parts and the diaphragm. "The diaphragm receives the phrenic nerve upon its upper part; the nerve spreads out in a web-like manner on the lower aspect; the phrenic is in close relation in the neck with the nerves which reach the shoulder, and below, it is brought into direct connection with the nervous supply of the liver on the one side, and with the vaso-motor filaments to the stomach on the other." Dr. Habershon tells us that in some cases it will be necessary to exercise care in the diagnosis, for intense pain in the side may be due to the neuralgia which precedes herpes zoster, or it may arise from disease of the spine, from local tumours or abscesses, from periostitis or perichondritis, from neuralgia dependent upon uterine disease, or from a direct injury, as a fractured rib.

Several cases of *hæmatemesis* from various causes are next given, and these are followed by some remarks on the internal administration of carbolic acid. After alluding to the employment of carbolic acid in diseases of the mouth, throat, and bronchi, Dr. Habershon calls attention to its use in many functional and organic diseases of the stomach in which fermentative action takes place, whether dependent upon the development of cryptogams or simply chemical in its nature. In any case, however, in which there is evidence of inflammatory disease of the stomach, the acid is contraindicated. On the other hand, in cases where the tongue is pale and flabby, even if furred, and the general symptoms are those of weakness, the acid will be found of service, especially if at the same time there is an absence of pain and tenderness except when distension occurs from the evolution of gases due to fermentation. It may be used even when gastric ulcers are known to exist, if the active stage of ulceration be passed.

Another indication for the employment of the remedy is flatulence, especially when the discharges from the bowels are mixed with large quantities of mucus. If diarrhœa coexist with flatulence, it is well to combine with it lime or an astringent, as gallic acid; if, on the contrary, constipation be the complication, the following formula will be of service: ℞.—Acid. carbolic., guaiac, resin, āā gr. j; pulv. rhei, gr. ij to gr. iij once or twice a day after meals.

The paper concludes with the report of two cases of injury to the head, and some remarks on that subject.

Art. XVIII. *On some Affections of the Nails*, by C. HILTON FAGGE, M.D.—The fact that the nails may become diseased, either in conjunction with the skin or independently of it, is perhaps not so generally and thoroughly understood as it should be. In this paper will be found cases of disease of the nails dependent upon parasites, upon secondary syphilis, or coexisting with the more ordinary forms of skin diseases. In one case an affection of the finger-nails occurred in a person who was suffering, it was believed, from Elephantiasis Græcorum.

Art. XX. *Numerical Analysis of the Patients treated in Guy's Hospital from* 1861 *to* 1868, by J. C. STEELE, M.D.—This analysis is similar to that which appeared in the journal of the *Statistical Society*, and which embraced the septennial period ending 31st December, 1861. From this analysis we learn that the hospital accommodation of Guy's consists of 572 beds, of which 344 are reserved for surgical cases, 216 for medical, and 12 are employed mainly for private cases. We regret that our limits do not permit us to give an abstract of this very valuable paper, which we would recommend all those specially interested in statistical inquiry to read. It is provided with fifteen tables. J. H. H.

We shall now invite the attention of our readers to those papers which are specially interesting to surgical practitioners; the first in order is

Art. II. *Statistics of Subclavian Aneurism*, by ALFRED POLAND.—This is an elaborate and very valuable paper, and was originally designed as an appendix to the author's "Case of Fusiform and Tubular Aneurism of the Subclavian Artery," which appeared in the last volume (vol. lii.) of the *Medico-Chirurgical Transactions*, and was noticed in the number of this Journal for April, 1870, page 472.

Mr. Poland has collected no less than 125 cases, of which, however, a few are not available for statistical purposes. He has carefully gone over the cases tabulated by Koch, and has been enabled to rectify several errors in the German writer's work; hence the present paper may be justly considered as the most important contribution yet made to the literature of subclavian aneurism. Mr. Poland's first table, which alone occupies twenty-eight pages of the "Reports," gives a synoptical view of the whole number of cases, classified according to the mode of treatment ultimately resorted to in each instance; and his second (of fourteen pages) shows the condition of the artery, of the sac and surrounding parts, and of the heart and arteries generally, in those cases in which a record as to these points has been obtained. Following these elaborate tables are various statistical deductions of great interest to surgeons: thus we find that in nearly three-fourths of the whole number of cases, the right side of the body was affected, 85 cases involving the right side exclusively, 28 the left, 2 both sides, and in 5 cases the side not being stated; the affection is much more frequent among men than among women, 100 cases occurring in the male sex against only 11 in the female. The *ages* of the males are recorded in 79 cases; of these in 24 the patients were under 40 years, in 28 from 40 to 49, in 17 from 50 to 59, and in ten over 60 years. Of 121 cases recorded, no less than 67 occurred in England, Scotland or Ireland, our own country furnishing 18, France 16, Germany 6, Russia 5, Italy 4, etc. etc. *Occupation* does not appear to exert any predisposing influence in causing the affection: "The occupation appears to be neither a predisposing nor an exciting cause, and this tends to show that the cause is much more general, viz., injury to which all are liable—or disease of the arterial system, to which all are equally prone under particular morbid circumstances. Few of the sufferers attributed the disease to their occupation, but rather referred it to some antecedent injury or blow, or to some affection, such as rheumatism, syphilis, etc." The *cause* of subclavian aneurism appears to be in more than half the number of cases an idiopathic change in the structural condition of the artery: in about one-third of the whole number of cases there was a history of injury, which was sometimes the only cause, and sometimes merely a concomitant with the previously existing structural change of the parts involved. The following table, which we quote, exhibits the facts bearing upon this point in a very succinct manner.

"*Résumé of Causes.*

A.—Direct Proof.				B.—Assumed or Conjectural.				
Assignable Cause.	Atheroma.	Dilatation.	Healthy.	Post mortem, but vessel not examined.	No post-mortem.	Recovery.	Uncertain.	Total.
Spontaneous . . .	17	5	...	7	3	15	...	47
Traumatic	13	3	4	10	3	9	1	43
None stated . . .	...	6	...	2	8	7	1	24
Specimens	3	...	...	...	...	...	4	7
Total	33	14	4	19	14	31	6	121

"Thus in 33 there were distinct proofs of atheroma.
14 the artery or aorta was dilated and the disease cannot be called traumatic.
25 the aneurism was acknowledged to be spontaneous; no evidence
— to the contrary.
72 cases, all fairly to be set down to idiopathic causes."

The *situation* of the aneurism is definitely stated in 98 cases; the whole course of the artery from origin to axilla was involved in 13, the first portion alone in 9, the first portion and innominate in 3, the first portion and carotid in 1, the second and third portions in 9, the second and third portions and the axillary in 1, the third portion alone in 25, the third portion and axillary in 26, and the axillary and confines of subclavian at first rib in 11.

The *size* of the aneurism varies greatly in different cases; various terms of comparison are used, ranging from a "small bean" or a "pigeon's egg," up to a "child's head" or a "forty-eight pound shot."

The most frequent *symptoms* are alteration of pulse (generally diminution) on affected side, pain, tingling, numbness, or anæsthesia; loss of motor power (occasionally accompanied with spasm); diminished temperature, with œdema; a sense of suffocation, dyspnœa, dysphagia, hæmoptysis, giddiness and fainting, insomnia (in one case drowsiness), contracted pupil, increased carotid pulsation (absence of pulsation in one case), turgid state of superficial veins, clubbed fingers, etc. Epilepsy occurred in one instance.

The affections which may complicate the *diagnosis* are, chiefly, (1) glandular and other tumors, (2) chronic abscess, (3) exostosis of the first rib, (4) neuroma of the brachial plexus, and (5) aneurisms of neighbouring vessels.

Mr. Poland's remarks upon "*the natural course, progress, and termination of subclavian aneurisms*," bring out one fact that we cannot but think extremely significant: this is that of 49 cases in which no active surgical treatment was employed, no less than 14 underwent a spontaneous cure; in 14 more the cause of death is not known or is known to have been some independent affection; while the aneurism itself certainly caused death in only 21.

The duration of life in fatal cases under different modes of treatment is illustrated by several tables, which show, as might be expected, that death, in fatal cases, is more rapid after the adoption of active surgical measures than after expectancy; this is, however, no argument against operation, for the risk of hastened death is, of course, one which is necessarily incurred in the practice of almost all operative procedures.

Mr. Poland reserves his *Statistics and Remarks on the Varied Methods of Treating Subclavian Aneurism*, for a future volume of the Reports, having already occupied a large portion (110 pages) of this, an act which, in our judgment, requires no apology, for we cannot conceive that the space could be better filled.

Art. III. is called *Some Remarks on Syphilis and Chancre*, by J. COOPER FORSTER.—This is a most sensible and practical paper, and we gladly commend it to the attention of all our readers: there is only one point which we are disposed to criticize, and that is the author's application of the term *chancre* to the non-infecting or simple sore, which we usually recognize under the name of *chancroid*. The word *chancre* is, we think, so firmly fixed in the minds of the profession as indicative of the initial lesion of syphilis, that it is futile to attempt now to invest it with a different meaning: better retain it with its present signification, and invent some new name (and we confess that neither chancroid nor simple sore is quite satisfactory) for the common, non-infecting, venereal, but not syphilitic ulcer.

From what we have said it will be perceived that Mr. Forster is, in the language of the day, a *dualist*; it is, indeed, to our mind, one of the most cheering signs of the time, that all practical and reasoning surgeons are gradually approaching uniformity of faith upon this topic: it will not, we suspect, be a great many years before the only remaining *unicists* will be, either those who cannot investigate the subject for themselves, or those who, of choice, blindly follow the doctrines of their predecessors, reverencing more the *idola* of authority than the instructions of nature.

Though clear in his faith, Mr. Forster (like every honest dualist) confesses the occasional impossibility of distinguishing the infecting from the non-infecting sore: hence he recommends early cauterization with nitric acid and lunar caustic in all doubtful cases: "Supposing the sore to be true syphilis, or about to become hard, no harm is done; and if it be a chancre or local soft sore only, it most assuredly will be thus destroyed, and a healthy, granulating surface will arise, which will quickly heal." With regard to constitutional treatment Mr. Forster says, "If I am called upon to see a sore that has existed some weeks, presenting the typical manifestation of hardness, and particularly if there exist any enlarged glands in the groin, I consider the application of an escharotic to the sore useless; I generally, under these circumstances, order small doses of mercury at once, either by fumigation, by inunction, or internally, in the shape of Pil. Hyd. Should, however, there be the slightest doubt in my mind of the true syphilitic character of the sore, I defer the remedy until the eruption appears, believing that I should do but little good by hastening its adoption." We are somewhat disposed to doubt the possibility of hastening or modifying the natural evolution of syphilis by the use of mercury during the primary stage; if, however, the "*pleiade ganglionaire*" be well marked, and if the patient (as often happens) be very anxious for constitutional treatment, we believe the safest preparation of mercury to be the protiodide, given in small doses, and well guarded with opium.

We observe that Mr. Forster condemns the application of caustics to phagedænic sores, relying upon frequent washings and the use of opium externally, and upon iron and opium "given internally in no sparing doses."

Art. IV. *Contributions to the Physiology of Binocular Vision*, by JOSEPH

Towne.—This, which is illustrated with two lithographic plates, is another of Mr. Towne's valuable papers on the physiology of vision, and is characterized by the same closeness of reasoning and clearness of description which marked its predecessors; it is not, however, a paper of which we can very well furnish an abstract, and as there is yet before us much of surgical interest in the present volume of "Reports," we will pass on to

Art. V. *Further Observations on Catarrh of the Tympanum*, by James Hinton.—This is a sequel to a paper published by Mr. Hinton in the last volume of the "Reports" [see number of this Journal for July, 1869, page 192], and gives additional proof of the benefits to be derived from incisions of the membrana tympani, and the evacuation of confined mucus. "Among the signs of the presence of mucus in the tympanum, a very characteristic one—though by no means constant, and not in itself to be taken as decisive—is the patient's own feeling of something being present in the ear, and moving as the head is moved. In some cases this feeling is so strong that it gives rise to the habit of giving the head a peculiar shake, as if to shake something in the ear out of the way, especially during the attempt to listen. Another peculiarity of hearing, which some time ago attracted my attention, but which I then failed to comprehend, I believe has a similar explanation, viz., the hearing better when the head is held down on the affected side. The difference is sometimes very marked, and I have recently observed it to exist with other palpable evidences of retained secretion." After incision of the membrana tympani, the accumulated mucus will sometimes project through the opening and may then be drawn out with forceps; in other cases it is necessary to resort to syringing with mild alkaline solutions "not by means of the Eustachian catheter, but in the opposite direction, applying the syringe to the meatus. The nozzle being well covered with elastic tubing, so as pretty closely to fit, without hurting, the meatus, the stream may be sent safely, even with considerable force, *provided the Eustachian tube be open*, and will flow freely through it, escaping by the nostril, the head, of course, being bent well forward. In this way masses of old secretion may be removed from the tympanic cavity in almost every case, and in some cases in quantities almost incredibly large. The cleansing by this means should be repeated frequently—every second or third day is best—until all appearance of any accumulation cease, and then a weak solution of sulphate of zinc (gr. ij–x ad ℥j) may be substituted and used in the same way." Obstruction of the Eustachian tube is a not infrequent complication of tympanic accumulation, and is usually remediable by inflation during swallowing, and by syringing through the tympanum, as above directed. In some cases, however, more active measures are required. "The most efficacious means for this end are, besides syringing solutions of the alkalies, or of nitrate of silver, or sulphate of zinc into the tube, the introduction of bougies of laminaria, or of very small elastic tubes passed through the Eustachian catheter, and along the tube as far as possible; air or fluids being then injected through them, so as to exert a direct pressure upon the constricted portion." Three cases are detailed in which recovery of hearing followed the treatment by incision, one in which only temporary improvement was obtained, and one which was not at all benefitted.

Art. VI. *Cases Illustrating the Diseases of the Upper and Lower Jaws, with Remarks*, by Thomas Bryant.—This valuable paper contains a record of forty-six cases, each of which is of interest to practical surgeons. The paper is divided into three parts, the first treating of necrosis of the bones entering into the formation of the jaws, the second of cystic tumours, and the third of solid tumours connected with the jaws. With regard to the treatment of necrosis, Mr. Bryant says, "When dead bone can be made out to exist, either in the upper or lower jaw, there is but one form of practice which ought to be entertained, and that is its removal. It should be removed, also, with as little disturbance to the soft parts or to the new bone-forming tissues, such as the periosteum, as possible, and it should likewise be removed from the mouth. When this latter practice is impossible or impolitic, from any cause, the surgeon should take good care that his incisions are made where they will be subsequently little seen. . . . In necrosis of the upper jaw the bone can always probably be removed by means of incisions made *beneath* the cheek; an incision *through* the cheek never seems necessary. In necrosis of the lower jaw, where incisions through the integument are demanded, they should be made below its lower border. When the bone is fixed, or, rather, before it has been thrown off from its attachments, any operative interference must be condemned. . . . Under these circumstances the surgeon should content himself with seeing that all pent-up pus has free vent, by making free incisions through the gum; that the patient's mouth is kept as clean as possible by frequent washings, and that his general condition is kept up by means of tonic medicines and nutritious diet." With regard to the treatment of cystic disease of the jaws, our author's remarks are equally judicious: "In every case in which the faintest suspicion exists of the cystic nature of the growth, operative interference should be confined to an exploratory operation, before the graver one of the extirpation of the growth is entertained. . . . In each of the cases which have been recorded, it will have been observed that the treatment was very simple, for a free incision into the cyst was made in all; the subsequent cure being effected by the production of inflammation of the cyst-wall by means of plugging its cavity with lint; although in the case of true dentigerous cyst the removal of the tooth through a free opening into the antrum was likewise needed. The opening in all the cases of disease of the upper jaw was made through the wall of the cyst, beneath the cheek, and not by perforating the socket of the first molar tooth after its removal, as is often advised. The opening at this spot can be made more easily, and may be made larger, and is more under observation. It should always be a free one. When the cyst is large, a piece of bone may be taken away, as was done in the instance quoted of dentigerous cyst." Mr. Bryant's paper is illustrated with four lithographic plates, and several wood-cuts.

Art. IX. *On the Torsion of Arteries: a Description of some Models made to Illustrate the Effects of Torsion; with Remarks*, by THOMAS BRYANT.—This short paper is adorned with a beautiful coloured lithographic plate representing several models executed by Mr. Towne, the well-known modeller of Guy's Hospital. They show at a glance, and better than can be done by any verbal description, the *modus operandi* by which torsion acts in effecting the closure of arteries. By the process of torsion the inner coats are divided, and in the majority of cases turned inwards, these incurved coats forming, in the most perfect examples, complete valves, not unlike the semilunar valves of the heart; in other cases "the valvular incurvation of the divided inner coats is not so perfect as to prevent the passage of a small portion of blood or injection with the first rush of fluid, although it is tolerably clear that the valve is subsequently rapidly closed with any increase or continuance of the injecting force. . . . In some cases this valvular incurvation of the inner coats is exchanged for a general splitting of the tissues, hemorrhage being prevented by the clotting of the blood between the irregular laminæ of the divided membrane and the twist of the external cellular coat." These models show the advantages of not twisting off the end of the vessel, for even when "the valve formed by the divided recurved inner coat proves to be perfect after the first rush of the blood current has taken place, the knot formed by the twisted external coat must prove a valuable support, and in doubtful cases, where an imperfect valve exists, it must be of still greater importance." When the inner coats are irregularly broken up, the presence of the twisted external coat is of value, "not only by forming an obstacle to the immediate escape of blood through the broken-up inner membrane, but by giving time to allow of complete coagulation of the blood which has been caught between the laminæ of the inner coats." Mr. Bryant's practical conclusions, from his experience in over one hundred cases, are:—

"That torsion may be safely applied to all arteries of the extremities, and to all those of the trunk which are in size less than or equal to the femoral. To the carotid and iliac vessels it has yet to be applied.

"That it is almost as applicable to diseased as to healthy vessels, the former requiring fewer rotations of the forceps than the latter.

"That in large healthy vessels, such as the femoral, the extremity should be twisted till resistance has been overcome, but no further—three, four, or five rotations of the forceps being, as a rule, all that is needed. These rotations should be made sharply.

"That in large atheromatous vessels the same rule should be applied, two or three rotations of the forceps generally sufficing.

"That in all small vessels torsion may be applied very freely, even to the separation of the end, although when evidence of disease exists it is better to proceed with more caution and not to twist off.

"That in every case where a large artery is twisted, it is advisable to allow a current of blood to flow into the vessel before the forceps are removed from its end. This caution not only tests the completeness of the act in all cases, but in doubtful ones facilitates the coagulation of the blood in the meshes of the broken-up inner membrane."

Art. XIII. *A New Method of Treating Gonorrhœa by Injections*, by ARTHUR E. DURHAM.—If Mr. Durham correctly represents the practice of the venereal wards of Guy's Hospital, we cannot wonder that he considers some improvement necessary in the treatment of gonorrhœa. This disease, he tells us, though simply a local affection, is (in the male) "rarely amenable to purely local treatment. Copaiba, cubebs, oil of sandal-wood, and other medicines, administered internally, are as much in vogue as ever, if not more so." Drugs are administered "which are often very nauseous to the patient, and are notoriously liable to disorder the stomach, and more or less affect the general health. In some cases . . . these drugs cannot be tolerated in any form, and the gonorrhœa almost comes to be considered the lesser evil." Treatment by injections "very often, indeed, utterly fails to do any good beyond amusing the patient until the gonorrhœa has, as it were, worn itself out. . . . in very many instances the prescribed injections have been of little real benefit; . . . in some instances positive mischief has been done; and . . . in comparatively few cases only have good results been manifestly effected." Mr. Durham's "new method" consists in the use of a slender tube of vulcanite, terminated at one extremity by an elongated bulb, and at the other connected by means of an elastic tube with an ordinary hand-ball enema syringe. "At the junction of the slender tube with the commencement of the bulbous expansion is a ring of minute perforations, which are made in such direction, that when the syringe is in action, the fine streams of fluid ejected through them pass backwards and upwards . . . and not straight onwards." The urethral tube is three to three and a half inches long, and of the calibre of a No. 3 or No. 4 catheter, the bulb being olive-shaped, three-eighths of an inch long, and at its largest circumference of the calibre of a No. 7, 8, or 9 catheter. A somewhat similar instrument was devised many years ago by Mr. Hilton; but it seems to us that in cases where it is necessary to resort to deep injections, Dr. Addinell Hewson's ingenious application of Thudichum's douche promises better than any other method. (See *Penna. Hosp. Reports*, vol. ii. p. 255, and No. of this Journal for July, 1869, p. 151.)

Art. XVII. *A Description of the Appearances of the Human Eye in Health and Disease as seen by the Ophthalmoscope. Fourth Series.—Glaucoma*, by C. BADER.—This short paper, like those previously published by Mr. Bader under the same title, is accompanied by beautifully coloured plates, on this occasion two in number, containing nine figures illustrating the ophthalmoscopic appearances in cases of chronic and of acute glaucoma. The following sentences may assist some of our readers in recognizing the condition known as "*cupping*" of the optic disk: "The course of the bloodvessels is altered; those on their way to and from the retina have to pass through the optic disk. The following alterations in their course are characteristic of the cupped condition of the optic disk, and to the less experienced ophthalmoscopist are the only reliable signs of the existence of a cupped optic disk. The greater number of vessels appears displaced towards the side of the cup, which lies nearest the yellow spot. The veins of the retina have to pass round the margin of the cup to reach their point of exit from the disk. If, as in advanced glaucoma, the margin of the cup is very prominent, a portion of the veins is hidden from view by that margin. The veins in the cup appear displaced compared with their corresponding portions in the retina; they do not seem to be the prolongations of the latter. This deceptive appearance is increased by the veins in the cup appearing much smaller than those in the retina ; some can barely be traced in the optic disk, others are lost sight of altogether. Even in the early stages of glaucoma we may see the trunks of the retinal vessels in the middle of the optic disk, instead of advancing straight forwards, to be bent towards the side of the disk nearest the yellow spot."

Art. XIX. *The Results of Amputations of Portions of the Limbs on account of Injuries and Diseases, especially in reference to the Causes of the Mortality after such Operations*, by JOHN BIRKETT.—In this valuable statistical paper are recorded 175 amputations in the continuity of limbs performed upon 171 patients, either by Mr. Birkett himself or under his immediate supervision, the cases having occurred during a period of seventeen years. There were four *double amputations*, three proving fatal, and the fourth (an amputation of the left thigh and arm in the case of a "hardy, healthy, and temperate labourer, twenty years old") eventually terminating in recovery.

Of the 167 cases of single amputations, nearly one-third ended in death, though in a large number of cases the fatal result was directly due to the traumatic lesion for which the operation was performed, the patients being, as Mr. Birkett puts it, "killed" by the effects of the injury. For the convenience of our readers we have compiled the following table, giving the numerical results of Mr. Birkett's 167 cases.

SEAT OF AMPUTATION.	PRIMARY.			SECONDARY.			FOR DISEASE.			AGGREGATE.		
	Cured.	Died.	Total.	Cured.	Died.	Total.	Cured.	Died.	Total.	Cured.	Died.	Total.
Thigh	4	5	9	2	8	10	44	10	54	50	23	73
Leg	12	6	18	4	6	10	11	4	15	27	16	43
Arm	7	6	13	5	5	10	2	1	3	14	12	26
Forearm . . .	12	1	13	1	...	1	10	1	11	23	2	25
Total . . .	35	18	53	12	19	31	67	16	83	114	53	167

It will be seen that the figures in this table fully bear out the established doctrine that the gravity of amputation increases directly with the proximity to the trunk of the point of operation, the apparent exception in the case of the leg and thigh being due to the fact that in the latter situation the amputations *for disease* greatly preponderate, these being, of course, the most favourable cases. Another point of interest is the greater mortality after *secondary* than after *primary* amputations for traumatic causes; a fact which has long been recognized in military surgery, but which is not acknowledged as true in civil practice by many writers, among others by no less eminent a surgeon than Mr. Erichsen (*Science and Art of Surgery*, last Am. edit., p. 62). We may add that from a careful tabulation of over 1800 cases, derived from a large number of civil sources, we are convinced that the distinguished Professor of University College is in error as to this matter, and that in civil, as in military surgery, primary is more successful than secondary amputation.

Mr. Birkett discusses in a very satisfactory manner the *causes of death in fatal cases* after amputation, and comes to the following conclusion, which seems to us amply warranted by his premises : "From the above evidence we may conclude that a large proportion of the patients submitted to amputation, when inmates of a metropolitan hospital, are the subjects of more or less advanced chronic disease of the thoracic or abdominal viscera. It is true that the immediate cause of death may be an acute inflammatory attack of a vital organ, to which it is reasonable to suppose diseased persons may be more prone than healthy ones, but the facts show, at the same time, that 'the chances of death after operations appear to depend almost entirely upon the previous state of each patient's constitution,' as stated by Dr. Chevers." (See an able paper by Dr. Norman Chevers on the causes of death after injuries and surgical operations, published in *Guy's Hospital Reports*, 2d series, vol. i. (1843), pp. 78–102.)

In closing this, the thirtieth volume of Reports issued by the Medical and Surgical Staff of Guy's Hospital, we cannot refrain from again expressing our high appreciation of the unequalled series which it so worthily prolongs. Oldest and best of all the Hospital Reports, the "Guy's" need fear no rival: long may it continue, as it has for more than the third of a century, to send forth from time to time its noble contributions to practical medicine and surgery, an honour to its own country, and a positive boon to the cause of science throughout the whole civilized world. J. A., Jr.

ART. XXII.—*St. George's Hospital Reports.* Edited by JOHN W. OGLE, M.D., F.R.C.P., and TIMOTHY HOLMES, F.R.C.S. Vol. IV., 1869. 8vo. pp. viii., 354. London: John Churchill and Sons.

THIS volume contains twenty-one papers, of which eleven are medical, and for the most part are of unquestionable value and interest. We shall first notice these, and afterwards the articles specially pertaining to surgery.

Of the medical papers the first is:—

Art. I. *On the Variations of the Acidity of the Urine that occur when Vegetable and Mineral Acids are used*, by H. BENCE JONES, Esq.—The opening paper of the volume is another of those valuable contributions to the study of physiological chemistry which have rendered its author's name familiar to the medical student. Not long ago Dr. Jones was assured that lemon-juice occasionally made the urine alkaline. Doubting the correctness of this statement he instituted a number of experiments to determine the effect of the vegetable and mineral acids upon the acidity of the urine. In his first series of experiments the acidity of the urine was determined for twenty-four hours before any lemon-juice was taken, and this, like those he before made,[1] and which were subsequently confirmed by Dr. Wm. Roberts, of Manchester, showed the close relation existing between digestion, and the reaction of the urine.[2] In the second and third series of experiments the variations of the acidity of the urine when lemon-juice and dilute sulphuric acid, respectively, were taken, was observed. It was found that the natural variations of the acidity of the urine are so great as almost to hide the effect which even twelve ounces of lemon-juice in the day can produce. The decrease of acidity that occurred when food was taken was just as great on the day the citric acid was taken as it was on the day when none was taken. Hence Dr. Jones concludes "that lemon-juice and tartaric acid have the same action in increasing the acidity of the urine, and that neither of these acids, even when taken in very large doses, produces as much effect on the acidity of the urine as is produced by the action of digestion." The action of digestion so far surpasses the action of large doses of lemon-juice on the urine that if the urine had only been examined four hours after breakfast, its alkalescence might have been attributed to the action of the lemon-juice. The statement that lemon-juice makes the urine alkaline, undoubtedly arose from some observation of this kind.

"When accurate observations are made," the author holds, "it will never be found that lemon-juice, or any other free vegetable or mineral acid, can cause the urine to become alkaline; although, when there is an irritable stomach, the urine may frequently be found to be alkaline during digestion, even when vegetable and mineral acids are taken in large quantities."

Art. II. *A Case of Angina Pectoris, with remarks*, by J. LOCKHART CLARKE, M. D.—In this case extensive disease of the heart must have existed for some time before the appearance of any striking symptom, and the sudden manner in which these symptoms supervened, on a seemingly healthy condition,

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[1] Animal Chemistry (H. Bence Jones), London, 1851, p. 41.

[2] Vide Am. Journ. of Med. Sci., April, 1870, p. 507.